Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL AT RENAISSANCE
P O BOX 9705
MCALLEN TX 78502

Respondent Name
CHARTER OAK FIRE INSURANCE CO

Carrier's Austin Representative Box
#05

MFDR Tracking Number
M4-11-4977-01

MFDR Date Received
AUGUST 29, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken From The *Table of Disputed Services*: "Labor Code 134.403"

Amount in Dispute: $9,746.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…The Carrier disagrees with the Provider's MAR calculation, however, as the Carrier shows the MAR value for these services to be $45,683.58, not $46,212.29 as represented by the Provider. Additionally, the Provider's position omits the contract between the Provider and the Carrier. The reimbursement issued to the Provider was based on the contractual discount rate from the MAR as set forth in the contract. The Provider has acknowledged the existence of the contract in their documentation, where their request for reconsideration references the PPO discount; however, the percentage reduction is incorrect. The Carrier has reviewed the calculation and contract provisions, and determined the Provider was correctly reimbursed under the terms of the contract. The Carrier contends the Provider is not entitled to additional reimbursement for the admission at issue. The Carrier contends the Provider is not entitled to additional reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 7, 2010 through December 10, 2010	Inpatient Hospital Surgical Services	$9,746.01	$9,209.95

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility

fees for inpatient services.

3. 28 Texas Administrative Code §133.4 sets out the guidelines for written notification to health care providers of contractual agreements for informal and voluntary networks
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 14, 2011
   - DPAY — W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. RE-PRICED IN ACCORDANCE WITH THE DRG RATE.
   - INCG — W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. RE-PRICING INCLUDED IN THE DRG RATE.
   - IMPL — 16— CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. NOT DOCUMENTED. INVOICE NEEDED.
   - AFFB — 45— CHARGE EXCEEDS FEE SCH/MAX ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. BILL HAS BEEN REVIEWED/REPRICED IN ACCORDANCE WITH YOUR FEE FOR SVC CONTRACT WITH FIRST HEALTH. QUESTIONS CALL 800.937.6824

   Explanation of benefits dated March 4, 2011
   - CTYR — 131— CLAIM SPECIFIC NEGOTIATED DISCOUNT. BASED ON ADDITIONAL INFORMATION RECEIVED, ADDITIONAL PAYMENT WAS PROCESSED PER YOUR COVENTRY CONTRACT. QUESTIONS CALL 800.937.6824

   Explanation of benefits dated April 13, 2011
   - T179 — W1— WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. SUBMITTED SERVICES WERE REPRICED IN ACCORDANCE WITH STATE DRG GUIDELINES.

   Explanation of benefits dated May 26, 2011
   - CTYR — 131— CLAIM SPECIFIC NEGOTIATED DISCOUNT. BASED ON ADDITIONAL INFORMATION RECEIVED, ADDITIONAL PAYMENT WAS PROCESSED PER YOUR COVENTRY CONTRACT. QUESTIONS CALL 800.937.6824

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The insurance carrier reduced disputed services with reason code "AFFB — 45— CHARGE EXCEEDS FEE SCH/MAX ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. BILL HAS BEEN REVIEWED/REPRICED IN ACCORDANCE WITH YOUR FEE FOR SVC CONTRACT WITH FIRST HEALTH. QUESTIONS CALL 800.937.6824." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on October 11, 2011 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier

payment amount shall be multiplied by:
(A) 143 percent; unless
(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

3. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is 460, and that the services were provided at Doctors Hospital at Renaissance. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $31,946.56. This amount multiplied by 143% results in a MAR of $45,683.58.
4. The division concludes that the total allowable reimbursement for the services in dispute is $45,683.58. Based upon the cancelled checks submitted by the requestor, the respondent issued payment in the amount of $36,473.63. Based upon the documentation submitted, additional reimbursement in the amount of $9,209.95 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $9209.95.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $9,209.95 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date
	Greg Arendt	April 11, 2013

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.